STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011479	A. BUILDING: _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORTHOPAEDIC HOSPITAL OF LUTHERAN HEAL	7952 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00132284 Unsubstantiated: lack of sufficient evidence. Date: 8-15-13 Facility Number: 011479 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor The Orthopaedic Hospital of Lutheran Health Network is in compliance with 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-7, Pharmaceutical services, Indiana Hospital Licensure Rules. QA: claughlin 08/20/13	S 000		